Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

Quality care in community hands. Planning for the future.

2008-2009 Annual Report

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Local Health Integration Networks - Right Care, Right Place, Right Time

With the Ontario launch of Local Health Integration Networks in 2005 a wave of change in health care began. No longer would our health care system be centrally managed. Today, 14 Local Health Integration Networks (LHINs) are responsible for planning, integrating and funding the health services for community support services, long-term care homes, community health centres, mental health and addictions services and hospitals.

The benefits of the LHIN model are many. Health care planning and decision making are taking place close to home so that local needs can be identified and addressed. LHINs enable continuous and meaningful engagement with the communities they serve and the health service providers that deliver the care. And they allow for flexible solutions to meet community needs.

The early work of the LHINs has been grounded by an Integrated Health Service Plan (IHSP), a blueprint for early health improvement priorities. The HNHB LHIN IHSP (2006) was shaped by priorities identified in 2005 and informed by the advice of community residents and health service providers. The LHIN Board and staff continue to carry out that plan in concert with health service providers and community members.

On April 1, 2007, LHINs across the province received funding authority and responsibility for monitoring local health service providers. This is our second annual report since LHINs attained their full mandate.

Table of Contents

The Hamilton Niagara Haldimand Brant Local Health Integration Network....1

Message from the Board Chair....4

The HNHB LHIN Board of Directors....5

Message from the CEO....7

Our Hamilton Niagara Haldimand Brant LHIN....9

Continued Evolution of the HNHB LHIN

- Our Organization....12
- Connecting with our Communities....13
- Working Together: Building an Integrated Health System....15
  - Health Service provider Integration Initiatives
  - Integrated Health Service Plan (IHSP)
  - Regional Joint Assessment Centre (RJAC)
  - Wait Time Strategy
  - Chronic Disease Prevention and Management
  - e-Health
  - Emergency Services Steering Committee
  - Alternate Level of Care (ALC) Steering Committee
  - Aging at Home Strategy

Hamilton Niagara Haldimand Brant LHIN MLAA Performance Indicators 2008/09....23

Financial Statements....24

Notes to the Financial Statements....29

HNHB LHIN Contact Information....39

The Hamilton Niagara Haldimand Brant LHIN

Vision

A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Mandate

To plan, fund and integrate the local health system to provide appropriate, coordinated, effective and efficient health services in Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk.

Mission

To ensure availability of, and access to, linked services in order to improve the health of the population and the continuity of health care.

Values

Respect; Integrity; Accountability

We work from the approach of being a catalyst for change; with a viewpoint based on the individual, and their caregivers, who need to access local health services.

To achieve this we are committed to:
Transparency; Collaboration; Innovation; Real conversation

Message from the Board Chair – Juanita G. Gledhill

This past year has been a significant developmental year in the lifecycle of the LHIN model. Throughout our development as an organization, and particularly over the past year, we have capitalized on our freedom to think creatively and explore possibilities. We have been very fortunate to collaborate with residents, health service providers and other stakeholders across our LHIN who share our passion and commitment to strengthening our health care system with an approach that facilitates endless possibilities.

In the past year, we have strengthened existing relationships and developed new ones. We have witnessed voluntary integrations to reduce duplication of services and improve access to high quality care and we have promoted the health of seniors and supported them in living independently. We created a forum to better understand, respect and respond to cultural and ethnic diversity, and we have collaborated to improve the care of those with chronic disease.

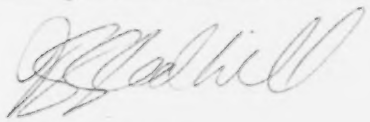
At the very heart of why we exist, our raison d'être, is you the citizens in our communities. You, your unique characteristics and the rich stories you share form the foundation of what we do and why we do it. That is why we create opportunities to hear your voice. We encourage you to attend our open board meetings, invite a speaker to your organization, participate in open houses and join our committees. Engaging in real conversations provides us with unparalleled insight into the potential for a coordinated, effective and sustainable health CARE system across our communities and further fuels our optimism and confidence that we are well on our way to realizing the possibility of a true local health care system of service delivery.

At the end of the day, we all want equal access to quality health care services whenever, and if ever, we need them. As not only the Board Chair, but also as a resident of the Hamilton Niagara Haldimand Brant LHIN, I truly believe we are making substantial progress in achieving a health care system that keeps people healthy, gets them good care when they are sick, and is there for our children and grandchildren. We acknowledge that as we make decisions to bring us closer to this vision, those decisions bring about changes and change can be very difficult and challenging for some in our communities. We are responsible for helping everyone understand the necessity and future benefits of the outcomes of our decisions.

We realize our vision would not be possible without the participation of our residents, health service providers and stakeholders. I am sincerely grateful for and appreciative of your enthusiastic involvement and support.

I would particularly like to acknowledge and thank my Board colleagues, for their commitment to improving the health care experience and to local decision making; CEO Pat Mandy, for her leadership and dedication to our vision and for her leadership of our organization; and her team, whose tireless efforts result in real, positive outcomes for the people in our communities. Thank you for joining me in exploring the possibilities that local health care system planning and decision making affords us.

It continues to be an honour and a privilege to serve the citizens of Hamilton, Niagara, Haldimand, Brant, Burlington and Norfolk as Chair of our LHIN Board.



Juanita G. Gledhill

The HNHB LHIN Board of Directors

Juanita G. Gledhill, Chair

Appointed: June 1, 2005 • Term: 3 years
Re-appointed: June 2, 2008 • Term: 3 years

"Our Board has continued to evolve the LHIN model of local decision making by community members. Our work and our decisions have been challenging yet clearly focused on the goal of moving towards a health care system which keeps people healthy, gets them good, quality care when they are sick and will be there for our children and grandchildren. Change may be difficult, but it is necessary to achieve this vision."

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Jack Brewer, Vice-Chair

Appointed: June 1, 2005 • Term: 3 years
Re-appointed: June 2, 2008 • Term: 3 years

"The role of the LHIN to represent the needs of individuals in the community through strong guidance and co-operation with community boards is starting to have a meaningful impact on health care services to the public. This is being achieved through willingness by all interested parties to embrace change, adopt new approaches and work more effectively with their peers to maximize the potential for improved health care delivery. This includes health care workers, governing bodies, volunteers and most importantly the general public."

****

Douglas Archibald, Member

Appointed: May 9, 2007 • Term: 2 years
Re-appointed: May 9, 2009 • Term: 3 years

"One of the unexpected pleasures has been meeting the staff and volunteers of the various support groups who selflessly devote their time and efforts in assisting the less fortunate and who ensure that the LHIN Board decisions are successfully realized in terms of benefits to the Community. I feel very strongly that the importance of community engagement and interaction cannot be over-emphasized."

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Carolyn King, Member

Appointed: January 5, 2006 • Term: 13 months
Re-appointed: February 5, 2007 • Term: 3 years

"While it has been a challenging year for the LHIN Board with many major decisions on the way health services are delivered in our communities, our Board continues to support the LHIN model of stronger local decision making and a stronger patient-centred care model."

****

Bob Lawler, Member

Appointed: October 29, 2008 • Term: 3 years

"The LHIN is now coming of age. Over the last fiscal year, the LHIN has had to make or reaffirm decisions that recognize the fact that we have finite resources in which to provide quality care with reasonable access. Some of these decisions were not popular but have to be done to insure we have a health care system that is there for our children and grandchildren."

****

Bill McLean, Member

Appointed: May 17, 2006 • Term: 2 years
Re-appointed: May 17, 2008 • Term: 3 years

"I have the opportunity and privilege to speak with local citizens about their health care services and one message I hear repeatedly from seniors is their wish to live independently for as long as possible. Long term care homes are far from their first choice and they are embracing the provincial Aging at Home Strategy. We need to do everything possible to support the numerous Aging at Home projects. Our seniors want and deserve this type of help and support."

****

Bill Millar, Member

Appointed: March 7, 2007 • Term: 2 years
Re-appointed: March 7, 2009 • Term: 3 years

"Some of the decisions we have taken over this past year have raised concerns, even conflict, in the communities involved. We must continue to listen to, learn from and respond to those concerns. It will be important as we move forward, to come to a shared understanding with our fellow citizens of the new realities of health care delivery and the importance of rationalizing and integrating our resources in pursuit of improved quality, access and sustainability."

****

Janice Mills, Member

Appointed: May 17, 2006 • Term: 13 months
Re-appointed: June 17, 2007 • Term: 3 years

"2008-2009 was a year of important decision making for a number of health service providers in communities across our LHIN. The decisions supported and made by this Board have set in motion a period of change and growth in the delivery of services. In the coming year many important programs and plans will support these decisions and I am particularly excited about the Patient Centric Transformation Initiative – it will enable hospitals, CCACs and Family Health Teams access to the same information."

****

Stephen Birch, Member

Appointed: May 17, 2006 • Term: 2 years
Re-appointed: May 17, 2008 • Term: 3 years
Resigned: September 30, 2008

Message from the CEO – Pat Mandy

Another year has passed and I am confident we are moving in the right direction with continued success. Our achievements have been and will continue to be supported by the ongoing collaboration with our community partners and the dedication and commitment of our Board and staff.

We have now been in operation for four years and I believe we have transitioned beyond the start-up chapter of our organization and have moved into a phase where many endeavours are no longer brand new. In many instances, we have reference points which allow us to refine our practices for continuous improvement and enhanced outcomes for our LHIN.

During the past year we recruited our full staff complement and now serve our communities with an even greater wealth of knowledge and expertise. To support our growing organization, the LHIN office was relocated to an environment that more appropriately serves our staff and our community partners.

The 2008-09 year marks the implementation of the full scope of our mandate – to plan, fund and integrate the local health system to provide appropriate, coordinated, effective and efficient health services for the citizens of our LHIN.

We have made great strides in our initiatives and have several success stories to share:

- LHINs completed the first round of Multi-Sector Service Agreements (M-SAAs). Through various community engagement initiatives HNHB LHIN staff and the Health Service Providers (HSPs) in our communities have developed strong relationships. I believe it was this relationship building that facilitated the collaboration necessary to effectively complete the M-SAAs.

- In 2008, Hamilton Health Sciences and St. Peter's Hospital voluntarily merged their administrative and governance structures. The amalgamation of these two organizations will improve care for seniors and those with chronic illness through the sharing of best practices and resources and the creation of a system-wide approach to care.

- In September 2008, the HNHB LHIN Board did not stop the integrations outlined in Hamilton Health Sciences' Access to the Best Care (ABC) plan to move forward. In December 2008, the LHIN Board accepted a revised Hospital Improvement Plan (HIP) from the Niagara Health System (NHS) and also directed changes in service delivery at one of the NHS sites. In each case, these plans are part of the evolution toward a coordinated health care system within our LHIN.

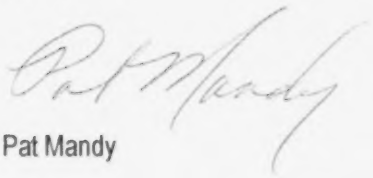
- LHIN staff embarked on an important planning initiative – a Clinical Services Plan (CSP). This plan will answer important questions about what services are needed where and who will provide those services. It will also help to inform the update of the Integrated Health Service Plan (IHSP). The CSP will be delivered to the LHIN Board in November, 2009.

- The 2008/09 year was the first year of implementation of the 31 initiatives which collectively received more than $7.6 million in Year One of the Aging at Home Strategy. Staff is in the process of developing performance indicators to measure the effectiveness and success of the programs funded.

- A follow-up session to last year's Aboriginal Health Search Conference was held to share the insights learned from the conference about what Aboriginal people think their health care experience should be. In attendance were a broad range of health care leaders, including those from provincial and federal bodies, hospitals and health networks.

The 2008-09 year brought about significant progress in fulfilling our mandate and I would like to acknowledge the remarkable work of our staff, as much of our success can be attributed to the efforts of each member of our organization. Our team goes above and beyond the call of duty to not only meet but exceed the expectations within each of their roles. They are also dedicated to supporting our Board so that all members are in the best position to make well-informed, educated decisions. I sincerely thank all staff for contributing to the positive changes in health care we continue to see throughout our LHIN.

I would also like to recognize and thank our Board for their dedication, leadership and commitment to living and breathing our vision – a health care system that keeps people healthy, gets them good care when they are sick, and will be there for our children and grandchildren. A special thanks to our Board Chair for her unwavering commitment to, and passion for, improving the health care experience for the citizens in our HNHB LHIN.



Pat Mandy

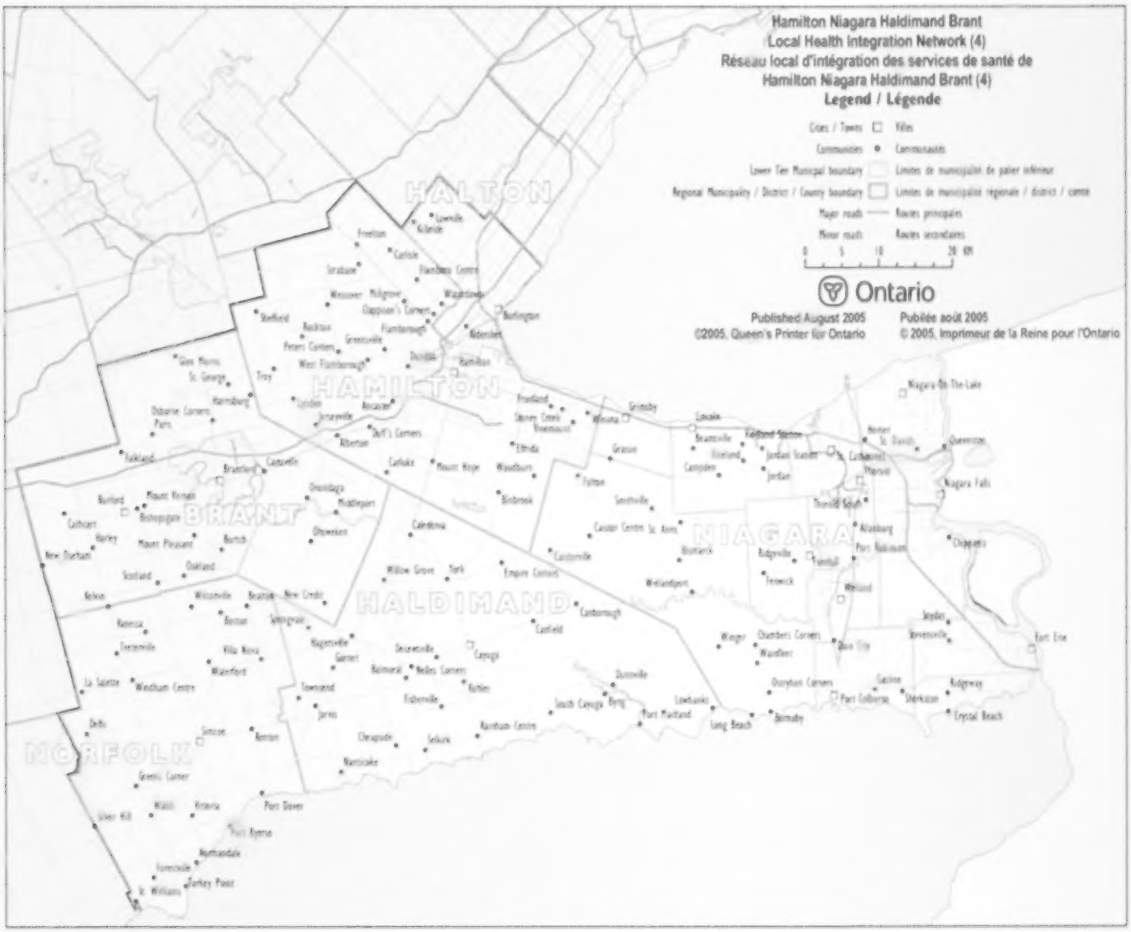
Our Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN)

The Population: Demographics

The HNHB LHIN is home to nearly 1.4 million people – about 11% of the population of Ontario. The HNHB LHIN population is estimated to grow 4.7% by 2014, and 9.6% by 2019 (Source: Population Projections, Provincial Health Planning Database).

While the total number of people 45-74 years old is growing the fastest, the largest changes will be among people ages 65-74 (growing by 43.5%) and over 84 (growing by 28.5%) over the next ten years. This change shows that HNHB LHIN's population is aging.

More than 200,000 seniors live in the HNHB LHIN which is the largest number of seniors of all Ontario LHINs (Source: Statistics Canada: 2006 Census).



The Population: Socio Demographic Characteristics

The HNHB LHIN has a diverse population. For 18% of HNHB residents, neither English nor French is their fist language. Francophones, First Nations, and urban and rural Aboriginal people are recognized populations in the HNHB LHIN. But compared to Ontario, the HNHB LHIN has a lower percent of immigrants and visible minorities.

HNHB LHIN has a higher percent of lone parent families, and lower percent of adults with post secondary education than the Ontario average.

	HNHB LHIN	Ontario	Range for all 14 LHINs
Total Population (2009)*	1,398,049	13,050,754	231,320 - 1,690,720
Senior population, age 65+ (2009)*	15.7%	13.6%	9.6% - 17.7%
Population with English mother tongue	80.1%	69.8%	51.5% - 91.5%
Population with French mother tongue	2.2%	4.4%	1.0% - 23.9%
Population who are immigrants	20.3%	28.3%	6.3% - 47.9%
Population who are recent immigrants (arrived between 2001-06)	2.3%	4.8%	0.3% - 9.5%
Populations who are visible minorities	9.1%	22.8%	1.4% - 50.3%
Population of Aboriginal identity	1.7%	2.0%	0.4% - 19.0%
Labour force participation rate (age 15+)	65.7%	67.1%	60.1% - 71.5%
Unemployment rate (age 15+)	6.0%	6.4%	5.2% - 8.4%
Population in low income	13.7%	14.7%	9.6% - 24.0%
Families (with children) headed by a lone parent	26.1%	24.5%	20.0% - 30.9%
Population (age 25+) without certificate, degree, diploma	20.8%	18.7%	13.0% - 25.9%
Population (age 25+) with completed post-secondary education	52.9%	56.8%	50.3% - 64.7%

*Source: *2009 population estimates. Remaining indicators based on 2006 Census of Canada, Statistics Canada*

The Population: Health Status

Self-reported health can show aspects of health not captured in other measures. Similar to Ontario's rates, more than 60% of HNHB residents rate their health as 'excellent' or 'very good' (Source: Canadian Community Health Survey, 2007). However, significantly more HNHB LHIN residents say they are limited in activities because of a physical or mental condition or health problem.

The Population: Illness, Disease and Death

Chronic conditions reduce the quality of life of those who suffer from the condition. HNHB LHIN residents have significantly more arthritis/rheumatism, high blood pressure, and asthma compared to the province as a whole. Diabetes rates are slightly, but not significantly, lower than the provincial rates (Source: Canadian Community Health Survey, 2007).

Death rates reflect the overall health of the population. Lower death rates show success in preventing, detecting, and treating disease, and reducing suicide. In 2004, there were 10,828 deaths among residents of the HNHB LHIN. Heart disease, lung cancer, and stroke were the top three leading causes of death.

HNHB residents lose more potential years of life. Potential years of life lost rates are useful for measuring the number of years of life "lost" from deaths that occur "prematurely" (i.e., before age 75). Deaths, potential years of life lost and hospitalization rates in the HNHB LHIN are higher than provincial rates (Source: Deaths, Provincial Health Planning Database).

The Population: Health Practices and Preventive Care

Poor health practices increase the risk of chronic disease, disability, and death. Relative to the province, more people in the HNHB LHIN smoke daily or occasionally, drink heavily, and are obese (Source: Canadian Community Health Survey, 2007).

Preventive health care services can help find disease early, which over the long term reduces illness and death. Of the selected preventive health indicators, none are significantly different from Ontario as a whole. Within the last three years, 71.7% of women in the HNHB LHIN had a Pap smear (for cervical cancer screening), 54.5% of women received a routine mammogram in the previous two years, and 36.9% had a flu shot in the past year (Source: Canadian Community Health Survey, 2005 and 2007).

Most people get their care through their family doctors. Doctors also play a key role in coordinating care and managing chronic conditions. Most people (79.0%) in the HNHB LHIN talked, either in person or by phone, with a doctor in the last year. This is similar to the Ontario rate of 80.6%.

Summary

The HNHB LHIN covers 7,000 km^2, encompassing Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk. With approximately 1.4 million people, it includes small rural communities and large urban centres, with population that is culturally and linguistically diverse.

Relative to the province (Ontario), HNHB has a higher percent of:

- lone parent families
- people limited in their daily activities
- daily or occasional smokers
- people who are obese
- people with arthritis/rheumatism, high blood pressure, and asthma

The HNHB LHIN also has

- the most seniors of any LHIN
- a higher rate of premature death and hospitalization
- a lower percent of adults with post-secondary education

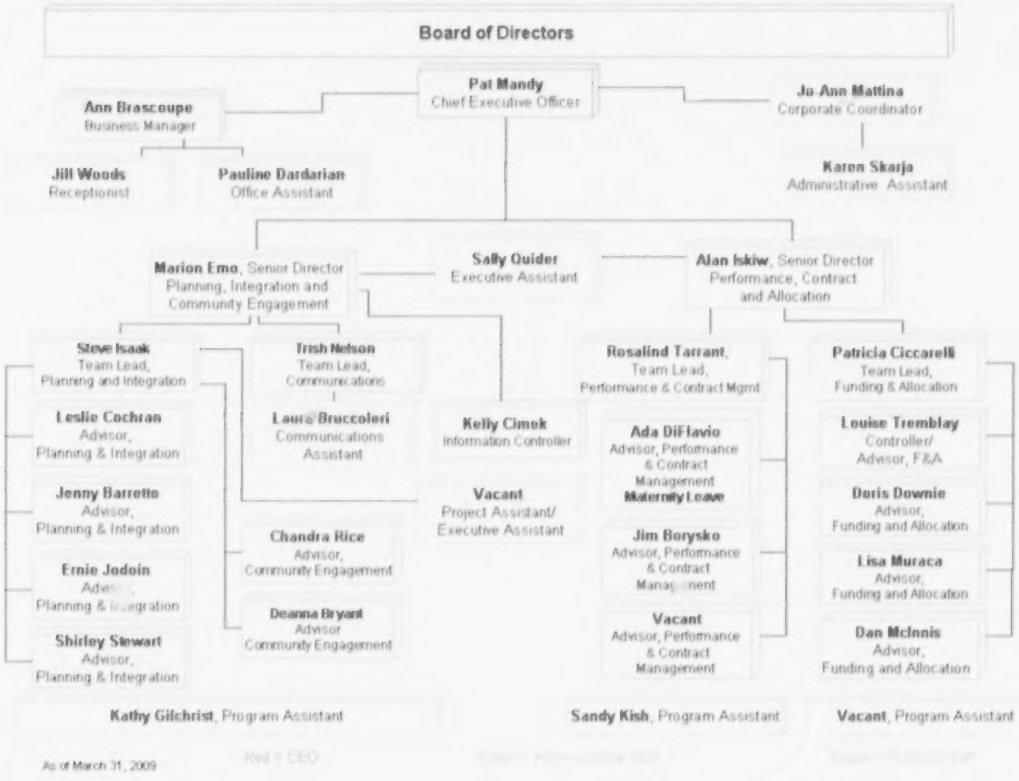
Continued Evolution of the HNHB LHIN

Our Organization

Staff

The HNHB LHIN staff complement continued to grow in numbers and diversity. The range of skills, knowledge and experience have been honed in health and human services planning, funding and coordination, capacity development, epidemiology, performance measurement, project management, accounting, public health and communications. Staff is guided by the values and principles of the organization including respect, integrity and accountability and to achieve this staff is committed to transparency, collaboration, innovation and real conversations.

With the increased growth in staffing numbers, relocation to a larger administrative space was necessary and in late-October 2008 the HNHB LHIN office moved into a new building. The office remains in Grimsby - the geographic centre of the area served by the HNHB LHIN.



Board Members

2008-2009 saw only two changes to our Board of Directors.

Leaving the Board – Stephen Birch submitted his resignation on September 30, 2008.

Joining the Board – On October 29, 2008, Robert (Bob) Lawler joined our LHIN's Board of Directors. Bob brings extensive experience in the health care industry and a wealth of knowledge and expertise to the Hamilton Niagara Haldimand Brant LHIN. Prior to his current role as Executive Director of Credit Counselling of Regional Niagara, Bob spent several years in various capacities within health care. Bob was the president and CEO of St. Catharines General Hospital for seven consecutive years, during which time he also served five of those years as Executive Director of the Niagara-on-the-Lake Hospital. Bob was also involved with Hospice Niagara, Ontario Hospital Association and Service Employees International Union (SEIU). We welcome Bob to our Board and look forward to his ongoing contributions.

Relationship between the Board and Senior Management

Our LHIN Senior Leadership Team includes the CEO, Senior Director – Performance, Contract and Allocation, and the Senior Director – Planning, Integration and Community Engagement.

Senior Leadership Team members attend the regular Board meetings and present monthly verbal and written reports to the Board on the activities in their respective portfolios. Led by the CEO, the Senior Leadership Team guides strategic operations of the organization.

The Board provides ongoing direction to the CEO through:

- Regular meetings
- Board committees
- Policy direction
- Performance appraisal

Connecting with our Communities

Community engagement and relationship building are integral to the work of the LHIN and all stakeholders if we are to achieve an improved health system. By listening to our residents, local health service providers and strategic partners, and by seeking input into plans before our LHIN, we are supporting community-level participation in health system decision-making. We have and will continue our efforts to reach greater numbers of people in our LHIN to include them in meaningful discussions around what changes are needed in our health system, and how best to make them. We continue to be reminded that health is more than health care and that health improvement solutions will benefit from collaborations among a broad range of health and related providers.

Over the past three years the HNHB LHIN has actively engaged the public, health service providers and other stakeholders in dialogue related to health service needs and opportunities for improvement within the health care system. Based on these discussions, we know that changes are needed in the way health care services are organized if we are to respond most effectively to the evolving health care needs of the population. These changing health care needs are being driven by a number of factors, such as:

- A growing and aging population that requires changes in the quantity and types of services available;
- Advances in medical technology (i.e., therapies, surgical techniques, medication), that are enabling people to live longer and in better health;
- Improvements in health care techniques and technologies that are changing the way we use hospitals, (e.g., increased day surgery, shorter inpatient stays); and,
- Advances in information and communication technology and the availability of health information, which are empowering people to assume greater responsibility for their own health.

While change is never easy, we are encouraged by the growing extent to which health service providers are collaborating across this LHIN in order to address growing needs in an era of scarce financial and health human resources.

This readiness for future-oriented, collaborative planning across the LHIN, means the time has come to create a plan for health system transformation. The Clinical Services Plan is a future oriented, system-wide, directional plan that will better inform decision-making for the allocation of resources to match current and future needs of the LHIN population. In other words it will answer important questions about what services are needed, where they're needed and who will provide those services. The Clinical Services Plan process was launched in January 2008 with three workshops for community leaders and work will continue throughout 2009-2010.

Of special note within the LHIN's mandated responsibility are the activities underway to network with the Francophone and Aboriginal communities in the HNHB LHIN.

A committed core group of administrative leaders continue to meet regularly to advise the LHIN on the health status of the Francophone population and ways to integrate concerns for the health system within its health transformation initiatives.

The Centre de Sante and Foyer Richlieu have played key roles in mobilizing the Francophone community by organizing and convening forums on the proposed regulation that would define the role and composition of an advisory committee to the LHIN.

Building on the success of the Aboriginal Health Search Conference held at the end of 2007-2008, the planning committee – Health Opportunities for Aboriginal People (HOAP) – reviewed the information shared by the participants and worked with a select group of participants to develop a framework that could honour the values and preferences of the people. The Eagle was selected as a symbol to represent how Aboriginal stakeholders and the LHIN would collaborate on Aboriginal health.

In September 2008, the participants reconvened to celebrate their achievements and share their message with a broad range of stakeholders including regional network leads, hospital CEOs, and staff from various ministries including children and youth services and health promotion.

The Search Conference results also enabled the LHIN to submit a proposal for federal funding to adapt provincial health services to better meet the needs of Aboriginal people. We were able to secure additional funding to focus on hospital discharge planning, access to children's mental health services and community health planning.

In addition, three Aging At Home proposals were approved by the Board in the amount to support transportation initiatives on and off reserve as well as programming needs at an urban shelter for Aboriginal seniors.

During 2008-09 the role of the conference planning committee has evolved as they began to interact with other planning processes at the LHIN. This has launched the group into a new phase of development to expand the membership and formalize their role in the region and define a relationship to the LHIN.

The HNHB LHIN continues to convene monthly meetings with staff from all LHINs who have responsibility for Aboriginal health. This group continues to nurture relationships with a multiplicity of stakeholders in Aboriginal health, such as First Nations Inuit Health Branch, Ontario Region and the Aboriginal Health Strategy Unity (Ministry of Health and Long Term Care).

Working Together: Building an Integrated Health System

Hamilton Health Sciences – Access to the Best Care (ABC) plan

Hamilton Health Sciences (HHS) submitted its plan for *Access to the Best Care* on August 6, 2008 to the HNHB LHIN - 3-5 year plan that described service alignments among the four (4) HHS sites and proposed a new urgent care centre in Hamilton.

Access to the Best Care highlighted the risks of continuing to provide acute hospital services at four (4) Hamilton hospital sites (Hamilton General, Henderson General, McMaster University Medical Centre, and St. Joseph's Healthcare Hamilton). It described the opportunities to redefine the role of the HHS sites and realign scarce resources to enhance quality outcomes, sustain multi site coverage, improve the work environment, support recruitment and retention, and maximize efficiencies.

The service realignments in cardiac, cancer, trauma and stroke care across two sites (General and Henderson) will improve program delivery, patient flow and outcomes for adult services provided by HHS, and offer a long awaited opportunity to build a Centre of Excellence at the Children's Hospital.

Adult inpatient consolidations at the Henderson and the General sites and the development of a Children's Hospital Centre of Excellence at McMaster will require realignments among Emergency Departments consistent with the respective site program configuration. The *Access to the Best Care* Report outlines approaches to ED site capacity enhancements, and proposes a new urgent care site to respond to care requirements that can be met outside and ED.

At its September 29 meeting the HNHB LHIN board allowed the Hamilton Health Sciences *Access to the Best Care* plan to move forward.

Niagara Health System – Hospital Improvement Plan (HIP)

At its May 20, 2008 meeting the HNHB LHIN board requested that the Niagara Health System (NHS) submit, no later than July 15, 2008, a Hospital Improvement Plan (HIP) to define the range and location of hospital based services required to provide accessible, quality care for the citizens of Niagara. The board expressed the need to have an Expert Advisor appointed to provide advice on the content of the NHS HIP and at its June

24 meeting Dr. Jack Kitts, President and Chief Executive Officer of the Ottawa Hospital, was appointed. The HIP was received by the board at its July 16 meeting and immediately forwarded to Dr. Kitts.

During the months of September and October, Dr. Kitts and his team attended and conducted numerous meetings and information sessions with stakeholders across Niagara and neighbouring communities in order to inform their review of the HIP. Dr. Kitts presented his report to the LHIN board on November 25, 2008 and the HNHB LHIN shared the report with the NHS.

The NHS chose to adopt the recommendations within Dr. Kitts report and created an Addendum to their HIP. However at its November meeting the Fort Erie Standing Committee did not approve the changes contained in the NHS HIP Addendum that affected the emergency department and inpatient beds at the Fort Erie site, therefore all references to those services were removed. This meant changes to the emergency department and inpatient beds at Fort Erie could not be considered as part of the NHS HIP.

At its December 16, 2008 Board meeting the HNHB LHIN accepted the NHS revised HIP and also issued a proposed integration that would direct NHS to make changes at its hospital site in Fort Erie and the integration order was passed at the January 27, 2009 meeting of the HNHB LHIN Board.

Health Service Provider Integration Initiatives

Our LHIN endorsed three voluntary integrations and issued one integration decision in the past year under Section 27 of the Local Health System Integration Act (2006).

- St. Peter's Hospital with Hamilton Health Sciences

On March 28, 2008, Hamilton Health Sciences Corporation (HHS) and St. Peter's Hospital (SPH) signaled their intent to the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) by letter to integrate under Section 27(3) of the Health Systems Integration Act (Act). Subsequently the LHIN was advised on April 25, 2008, that the respective Boards of Directors and corporate members had unanimously passed resolutions approving an amalgamation agreement between HHS and SPH. Since it is only the Minister of Health and Long-Term Care who can approve two hospitals coming together to amalgamate services, the LHIN can choose to consider supporting the amalgamation or not and can signal support or lack of support to the Minister. At its May 20, 2008 meeting the HNHB LHIN Board voted to recommend to the Minister the approval of the proposed amalgamation of St. Peter's Hospital and Hamilton Health Sciences. The HNHB LHIN Board noted a high level of confidence in both boards and the consolidated management teams and that it anticipates that there will be improved services and significant positive financial impacts.

- Hamilton Health Sciences – Access to the Best Care (ABC) plan

At its September 29, 2008 meeting, the HNHB LHIN Board of Directors allowed the Hamilton Health Sciences' *Access to the Best Care* plan to move forward by finding that it was in the public interest not to issue a decision ordering the parties not to proceed with three key integrations. The integrations included the transfer of clinical services from Hamilton Health Sciences (HHS) to St. Joseph's Healthcare Hamilton (SJHH) (and from SJHH to HHS); and the creation and site of a new Urgent Care Centre.

The proposal presents a 3-5 year plan that describes service alignments among the three acute care sites of HHS and the transfer of some services to SJHH, and proposes a new Urgent Care site in Hamilton.

The *Access to the Best Care* plan focuses emergency care provided at the McMaster University Medical Centre (MUMC) on the paediatric population. Once transitioned to a full paediatric Emergency Department in 2011, adult emergency care will be provided at three hospitals across Hamilton – Hamilton General Hospital, Henderson General Hospital and St. Joseph's Healthcare. The change to a paediatric Emergency Department at MUMC will be made once the new, expanded Henderson Emergency Department opens, the redevelopment of the General Emergency Department is complete, and the new Urgent Care Centre in west Hamilton is open.

Approximately 60% of patients now using the MUMC Emergency Department could be more appropriately cared for at an urgent care centre and as part of the *Access to the Best Care* plan, HHS will be establishing an Urgent Care Centre in west Hamilton. This addition to health services for the citizens of Hamilton is slated to open in late 2009/early 2010.

- Niagara Health System Hospital Improvement Plan (HIP) – Douglas Memorial site, Fort Erie

On December 16, 2008 the HNHB LHIN issued a proposed integration decision that would direct the Niagara Health System (NHS) to make changes at its hospital site in Fort Erie (Douglas Memorial). This decision was taken by the LHIN Board due to changes made to the Hospital Improvement Plan (HIP) Addendum. Changes contained in the HIP Addendum that affected the Emergency Department (ED) and inpatient beds at the Fort Erie site had been removed by the NHS Board when the Fort Erie Standing Committee did not approve the changes. This meant changes to the ED and inpatient beds at Fort Erie could not be considered as part of the NHS Hospital Improvement Plan. The integration decision was subsequently approved by the LHIN Board at its January 27, 2009 meeting. The integration decision directed, among other things, that the following actions be taken by NHS at its Fort Erie site: close the emergency department; establish a 24 hour a day, 7 day a week urgent care centre; close all acute care beds; and, create 3 to 6 monitored observation beds attached to the urgent care centre.

- Niagara Alcohol and Drug Assessment Service and Alcohol and Drug Treatment Centre

On January 20, 2009, the LHIN was notified by the Executive Director of the Niagara Alcohol and Drug Assessment Service (NADAS) of the intended merger of the Niagara Alcohol and Drug Assessment Program and the Alcohol and Drug Treatment Centre (ADTC) Niagara. The Boards of both organizations had identified the need to create a more integrated, seamless and flexible continuum of services for those people in the Niagara Region struggling with issues related to addictions. At its February 24, 2009 meeting the Board of the HNHB LHIN found that it was in the public interest not to issue a decision ordering the parties, Niagara Alcohol and Drug Assessment Service and Alcohol and Drug Treatment Centre (Niagara), not to proceed with the integration. This amalgamated organization will encompass the mandates, programs and staff of the existing agencies and will be known as the Community Addiction Services of Niagara.

Integrated Health Service Plan (IHSP)

The Integrated Health Service Plan, Phase1 (November 2006) identified strategies for early priorities for health improvement. Priority areas included mental health care for adults and children and youth, independent living for people as they get older, palliative care, and occupational health. Aspirations for improvement common to the priorities were: care close to home; enhanced provider skills and competencies; and, right care in the right place for optimal health outcomes. Community based champions for each of the priority areas developed and implemented strategies for change. The largest gains over the last three years are evident in the changing culture of solution building in the LHIN.

- Several LHIN-wide planning tables have voluntarily convened to address effectiveness and efficiency opportunities and sustained quality care.
    - These collaboratives are guided by performance expectations in health service provider signed agreements with the LHIN and shared responsibility and accountability for client and system outcomes. These collaboratives include among others, the Community Support Services Network, the Long Term Care Homes Council inclusive of non profit and private homes, the Geriatric Assessment Integration Network (GAIN), and patient flow tables – the Alternative Level of Care and Emergency Services Steering Committee.

- System wide action plans are guiding implantation strategies.
    - For instance, GAIN's directional report – Specialized Geriatric Services Priorities for the HNHB LHIN (July 2008) – prioritized requirements for improved equity of access to specialized geriatric services and is informing investments for independent living.

- Communities of practice are evolving as means to integrate knowledge transfer for best practice.
    - The HNHB LHIN received notification from the Registered Nurses Association of Ontario (RNAO) that it was selected as a "Best Practice Spotlight Candidate." Spotlight organizations play a key role in ensuring that all health care organizations and the healthcare system itself provide nursing care based on the latest research information. The aim is to create working environments where the most current research is used in day-to-day practice by all nurses. Our innovative proposal demonstrated how the concept of individual Best Practice Spotlight Organizations candidacy can be expanded to include groups of health service providers with the goal of broadening the development of evidence-based cultures, improving client outcomes and enriching the practice environment of health professionals. The HNHB LHIN proposal profiled the achievements of existing Best Practice Spotlight Organizations and other health service providers within the HNHB LHIN in implementing RNAO best practice guidelines.
    - HNHB LHIN residents benefit from quality palliative care, in part related to the partnership between the Provincial End-of Life Network and the Seniors Health Research Transfer Network whose activities promote equitable access to quality care.

- Partnerships across sectors are emerging.
    - Occupational health partners are working with Family Health Teams and Community Health Centres to implement early detection screening tools for improved work place health and risk reduction. An independent living strategy for isolated seniors through a calling program is a partnership between the Ministry of Community and Social Services (MCSS) and a LHIN funded community information service; the partnership links persons with a developmental disability and meaningful activity with at risk seniors living alone.

Regional Joint Assessment Center (RJAC)

The Regional Joint Assessment Center (RJAC), located at the Chedoke site of Hamilton Health Sciences provides an inter-professional team approach for clients identified as potential candidates for total joint replacements. The aim of the program is to reduce the wait time for those clients requiring surgery and provide non-surgical candidates access to individualized treatment plans to optimize their physical functioning. The Center recently expanded to include the Brantford General Hospital site of the Brant Community Healthcare System.

Wait Time Strategy

In 2008/09, the HNHB LHIN in collaboration with LHIN health service providers and the Ministry of Health and Long-Term Care achieved wait time reductions that exceeded or were within the LHIN's 2008-09 wait time target range for the following health services: cancer surgery, cataract surgery, hip and knee total joint replacements and MRI services.

This success is attributed to the commitment demonstrated by LHIN providers, the HNHB LHIN Advisory Committee and its five associated work groups that regularly monitor wait times and identify strategies to improve access for these services and other stakeholders. Some of the activities completed this year that resulted in reduced wait times include:

- Successful recruitment of experts in cancer urology surgery, increased operating room time for selected cancer surgeries.
- LHIN hospitals that provide cataract surgery have worked together to transfer resources and use materials more efficiently to reduce the wait time for people requiring cataract surgery.
- The opening of a new MRI at St. Joseph's Healthcare, Hamilton in October 2008.
- Review of wait list management to ensure accuracy in reporting.
- Review of surgical processes to maximize efficiency in the operating rooms.

While the wait time for planned (elective) cardiac by-pass surgery and CT scans remained relatively constant in 2008-09, LHIN providers have worked diligently to improve access to these services especially for those residents who need access to these services or an urgent or semi-urgent basis.

The LHIN has also seen improvements in the number of residents that are readmitted to hospital following a heart attack or visit the emergency room or are hospitalized for conditions that could be managed elsewhere. Some of the activities that have contributed to this improvement include:

- Improved access to advanced cardiac services (cardiac angiogram and coronary angioplasty)
- New Community Health Centre in Fort Erie/Port Colborne, increasing access to primary care.
- Community Care Access Centre Case Manager's presence in LHIN emergency rooms to identify those clients who need assistance/support to stay at home or are risk of being hospitalized.

In 2008-09 the LHIN also established an Emergency Services Steering Committee, comprised of emergency experts from hospitals, and Emergency Medical Services to identity additional strategies to improve access to emergency room services.

The LHIN has been challenged in 2008-09 to reduce the wait times for LHIN residents waiting to enter long term care homes or waiting in hospital for alternate level of care (ALC). Activities supported this year to improve patient flow include:

- Continuation of slow stream rehabilitation
- Increase in LTCH capacity through overbeds
- Identification of residents who need priority access to LTCH
- Increased community support to assist clients and families either return from home or to support clients stay in their own homes

While many of the strategies implemented have increased access to support services, their impacts have not been fully realized due in part to the timing of when they started.

Chronic Disease Prevention and Management (CDPM)

In 2008-09 the LHIN established a Diabetes Action Group (DAG) and their final report was approved by the HNHB LHIN Board at its December 16, 2008 meeting. The DAG identified two priorities for diabetes management in 2008-09:

- An inventory of diabetes education material
- Identification of management approach based on best practice guidelines for diabetic foot care

The HNHB LHIN Board also approved two proposals submitted by the DAG for improved access to diabetic foot care services.

In partnership with McMaster University the LHIN hosted a Continual Medical Education conference in November that focused on Rising the Bar for CDPM in the LHIN.

e-Health

The e-Health provincial strategy expectations of LHINs and providers are high. Moving forward e-health initiatives in the HNHB LHIN will require leveraging off existing investments and multiple parties are coming to the table.

The plans for implementation of the HNHB LHIN's e-Health strategy are ambitious. The level of co-operation in the LHIN positions us well to deliver on our obligations, and to take advantage of the opportunities that will become available over the next four years.

The readiness assessment of the LHIN was used as a baseline to determine the gap between current state and the desired level of readiness to roll out Release 1 of the provincial e-Health strategy, still to be announced. A draft tactical plan has been developed to close that gap. A Project Management Office has been staffed to take an operational lead in the LHIN's e-Health implementation. A sampling of projects that have been initiated include:

- Clinical Connect - Clinical portals will give access to needed pieces of information with a dashboard-like convenience accessible anywhere using a secure and single sign-on application. Early work will expand access to the portal from Hamilton Health Sciences to other hospitals, the CCAC and pilot a connection to a local Family Health Team.
- Diagnostic Imaging Repository – Work is under way in a collaborative project between HNHB and Waterloo Wellington LHINs to create a shared digital imaging network that allows hospitals across both LHINs to share digital diagnostic images and reports.
- Integrated Decision Support Warehouse – LHIN hospitals and the CCAC will provide monthly information extracts to a centralized data warehouse. Information within the warehouse will be three months old versus the 18 month old data available from the Canadian Institute for Health Information (**CIHI**). The data warehouse provides all HNHB LHIN hospitals with access to resources they normally wouldn't have been able to afford, for example, near real-time access to advanced decision support activities.

Emergency Services Steering Committee

The HNHB LHIN Emergency Services Steering Committee (ESSC) was formed in October 2008 after the dissolution of the former regional Emergency Services Networks in Hamilton, Niagara and Brant. The mandate of the ESSC is to provide leadership to the HNHB Health Service Providers and the LHIN in the planning and implementation of initiatives to improve service quality and wait times for Emergency Services. Membership is comprised of physician and administrative leaders from across the various stakeholders including Hospitals, EMS and Community Care Access Centre. Supporting the formation and ongoing work of the ESSC, has been the recruitment of a HNHB LHIN ED Coordinator and Administrative support, the creation of a LHIN-wide ED Directors Committee, and continued monthly meeting of ED Site physician leaders group.

To ensure good communication between ESSC and the multiple stakeholders a Collaborative Emergency Services web space hosted on the HNHB LHIN website was developed. This web space is a one stop shop for ESSC minutes, Expert Panel Reports, Pay-for-Results data, and HNHB LHIN hospital ED performance data.

Following the provincial Emergency Department Wait time strategy, efforts have been put towards the three main strategy objectives to reduce ER demand, increase ER capacity/performance and faster discharge of Alternate Level of Care (ALC) patients (the latter overseen by the HNHB LHIN ALC Steering Committee).

One initiative well underway to assist emergency rooms to decrease the demand, maximize LHIN resources and improve the quality of care for residents of LTC Homes is a Nurse Practitioner model of care. The successful recruitment of additional Nurse Practitioners (NP) increases the compliment to 8 NP across our LHIN that will work collaboratively with LTC Homes improving care for the residents and avoiding where possible the disruptive transfer to an ER.

Extensive planning and implementation has occurred in 2008/09 to increase ER performance. ESSC has been involved in the planning and monitoring of the provincial Pay-for-Results initiative which, in year one, has demonstrated a successful ED wait time reduction at the Niagara Health System. Building on the year one Pay-for-Results successes, locally and provincially, five hospital corporations in a collaborative peer review process have been approved to proceed with initiatives to reduce wait times in 2009/10.

Alternate Level of Care (ALC) Steering Committee

The ALC Steering Committee continues to meet monthly to assess the status and impact of current ALC strategies. In 2008/09 the committee assisted the LHIN advance its Wait Time Strategy by supporting such programs as Slow Stream Rehabilitation and LTC Home Overbeds. With the support and contribution of all LHIN hospitals, CCAC, community support services and long term care homes, the following initiatives have been successfully implemented:

- An educational brochure about moving to the right level of care as part of a LHIN-wide ALC Communication Plan.
- A standardized method for the designation, collection and measurement of ALC data across the LHIN.
- A common set of indicators to assess hospital patient flow related to long term home admissions.
- Implementation of best practices to improve patient transitions within hospitals and to the community.

To further its role in improving patient flow, the HNHB LHIN ALC Steering Committee has partnered with the HNHB LHIN Emergency Services Steering Committee.

Aging at Home Strategy

Our LHIN continued to embrace the three-year Aging at Home strategy announced in August 2007 and worked with stakeholders to allocate $7.6 million to more than 30 programs and services that promote healthy aging and independent living. In Year One, new resources began to close long standing gaps in day programs and caregiver support, and promoted peer support and intergenerational approaches for healthy families and communities to sustain quality of life for people as they get older.

In June 2008, in support of the Aging at Home Strategy provincially, then Minister of Health and Long-Term Care George Smitherman announced the allocation of eight vans to the HNHB LHIN to support seniors and provide transportation to, among other things, medical appointments. The HNHB LHIN worked closely with Community Support Services Niagara and the Canadian Red Cross to identify areas of need within our LHIN.

The Aging at Home strategy is the local incubator for health system transformation. The collaboration and innovation potential for independent living and healthy aging at home in the 21st century is enormous. There have been signs of new collaborations and readiness for new ways of work as we move forward.

Hamilton Niagara Haldimand Brant LHIN MLAA Performance Indicators 2008/09

Performance Indicator	LHIN 08/09 Starting Point	LHIN 08/09 Performance Target	Most Recent Quarter 2008/09 LHIN Performance*	FY 2008/09 LHIN Annual Results**	LHIN Met Target/ Within Corridor –YES/NO
90th Percentile Wait Times for Cancer Surgery	60	55	53	54	YES
90th Percentile Wait Times for Cardiac By-Pass Procedures	47	43	44	51	NO
90th Percentile Wait Times for Cataract Surgery	138	115	110	107	YES
90th Percentile Wait Times for Hip Replacement	194	182	160	167	YES
90th Percentile Wait Times for Knee Replacement	283	182	198	200	YES
90th Percentile Wait Times for Diagnostic MRI Scan	111	91	104	85	YES
90th Percentile Wait Times for Diagnostic CT Scan	48	39	50	48	NO
Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC)	344.57	340.00	348.51	329.21	YES
Median Wait Time to Long-Term Care Home Placement -All Placements	109.00	64.00	161.00	147.00	NO
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution	18.70	16.00	25.37	23.61	NO
Rate of Emergency Department Visits that could be Managed Elsewhere	29.76	27.50	26.66	26.14	YES
Readmission Rates for Acute Myocardial Infarction (AMI)	3.60	3.60	2.81	2.90	YES

NOTE:
* Performance indicators 1-7 = Q4 2008/09; and 8-12 = Q3 2008/09
** Performance indicators 8-12 (in the Annual Results Column) only include the average of Q1-3

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Auditors' Report

To the Members of the Board of Directors of the
Hamilton Niagara Haldimand Brant
Local Health Integration Network

We have audited the statement of financial position of the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") as at March 31, 2009 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Hamilton Niagara Haldimand Brant Local Health Integration Network as at March 31, 2009 and the results of its operations, its changes in its net debt and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
April 30, 2009

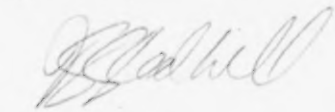
Member of
Deloitte Touche Tohmatsu

Statement of financial position

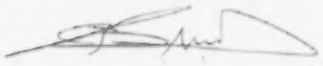
as at March 31, 2009

	2009	2008
	$	$
Financial assets		
Cash	**736,297**	780,017
Accounts receivable - Ministry of Health and Long-Term Care ("MOHLTC")	**223,200**	-
Accounts receivable - Other	**144**	4,796
Due from MOHLTC to Health Service Providers ("HSPs") (Note 9	**4,559,149**	6,898,982
Due from HSPs	-	1,018,000
	5,518,790	8,701,795
Liabilities		
Accounts payable and accrued liabilities	**962,921**	770,201
Due to the MOHLTC (Note 3b)	-	4,531
Due to the MOHLTC from HSPs	-	1,018,000
Due to HSPs from MOHLTC (Note 9)	**4,559,149**	6,898,982
Due to the LHIN Shared Services Office (Note 4)	**16,233**	11,844
Deferred capital contributions (Note 5)	**701,891**	460,145
	6,240,194	9,163,703
Commitments (Note 6)		
Net debt	**(721,404)**	(461,908)
Non-financial assets		
Prepaid expenses	**19,513**	1,763
Capital assets (Note 7)	**701,891**	460,145
Accumulated surplus	-	-

Approved by the Board



Juanita G. Gledhill, Board Chair



Jack Brewer, Vice Chair

Statement of financial activities

year ended March 31, 2009

	2009		2008
	Budget (unaudited) (Note 8)	Actual	Actual
	$	$	$
Revenue			
MOHLTC funding			
HSPs transfer payments (Note 9)	**2,342,686,000**	**2,385,618,620**	2,281,812,052
Operations of LHIN	**4,911,526**	**4,887,384**	3,961,793
E-Health (Note 10a)	**120,000**	**425,000**	275,000
Patient-Centric Transformation Initiative (Note 10b)	-	**223,200**	-
ER/ALC Performance Lead (Note 10c)	-	**33,300**	-
Health Force Ontario (Note 10d)	-	**50,000**	-
Emergency Dept LHIN LEAD (Note 10e)	-	**75,000**	43,800
Aboriginal Planning (Note 10f)	**37,500**	**49,000**	52,500
Wait List Management Activities	-	-	70,000
Aging at Home	-	-	295,000
Amortization of deferred capital contributions (Note 5)	-	**515,270**	224,907
	2,347,755,026	**2,391,876,774**	2,286,735,052
Expenses			
Transfer payments to HSPs (Note 9)	**2,342,686,000**	**2,385,618,620**	2,281,812,052
General and administrative (Note 11)	**4,911,526**	**5,402,654**	4,186,700
E-Health (Note 10a)	**120,000**	**425,000**	275,000
Patient-Centric Transformation Initiative (Note 10b)	-	**223,200**	-
ER/ALC Performance Lead (Note 10c)	-	**33,300**	-
Health Force Ontario (Note 10d)	-	**50,000**	-
Emergency Dept LHIN LEAD (Note 10e)	-	**75,000**	39,269
Aboriginal Planning (Note 10f)	**37,500**	**49,000**	52,500
Wait List Management Activities	-	-	70,000
Aging at Home	-	-	295,000
	2,347,755,026	**2,391,876,774**	2,286,730,521
Annual surplus before funding repayable to the MOHLTC	-	-	4,531
Funding repayable to the MOHLTC (Note 3a)	-	-	(4,531)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

Statement of changes in net debt

year ended March 31, 2009

	2009	2008
	$	$
Annual surplus	-	-
Acquisition of capital assets	**(757,016)**	(66,627)
Amortization of capital assets	**515,270**	224,907
Change in other non-financial assets	**(17,750)**	829
Increase in net debt	**(259,496)**	159,109
Opening net debt	**(461,908)**	(621,017)
Closing net debt	**(721,404)**	(461,908)

Statement of cash flows

year ended March 31, 2009

	2009	2008
	$	$
Operating		
Annual surplus	-	-
Add items not affecting cash		
Amortization of capital assets	**515,270**	224,907
Less items not affecting cash		
Amortization of deferred capital contributions (Note 5)	**(515,270)**	(224,907)
	-	-
Changes in non-cash operating items		
Decrease (increase) in accounts receivable - other	**4,652**	(1,658)
Increase in accounts receivable - MOHLTC	**(223,200)**	-
Decrease (increase) in due from MOHLTC to HSPs	**2,339,833**	(6,898,982)
Decrease (increase) in due from HSPs	**1,018,000**	(1,018,000)
Increase in accounts payable and accrued liabilities	**192,720**	166,395
(Decrease) increase in due to the MOHLTC	**(4,531)**	4,531
(Decrease) increase in due to the MOHLTC from HSPs	**(1,018,000)**	1,018,000
(Decrease) increase in due to HSPs from MOHLTC	**(2,339,833)**	6,898,982
Increase (decrease) in due to the LHIN Shared Services Office	**4,389**	(67,663)
(Increase) decrease in prepaid expenses	**(17,750)**	829
	(43,720)	102,434
Capital transactions		
Acquisition of capital assets	**(757,016)**	(66,627)
Financing transactions		
Increase in deferred capital contributions (Note 5)	**757,016**	66,627
Net (decrease) increase in cash	**(43,720)**	102,434
Cash, beginning of year	**780,017**	677,583
Cash, end of year	**736,297**	780,017

1. Description of business

The Hamilton Niagara Haldimand Brant Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2009.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Counties of Hamilton, Niagara, Haldimand, Brant, most of the County of Norfolk and the City of Burlington. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital asset and impairment in the value of assets.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any MOHTLC managed programs.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

2. Significant accounting policies (continued)

Capital assets (continued)

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method
Infrastructure/web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year. Infrastructure/web development costs are included with computer equipment for accounting and reporting purposes.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Revenue	**Expenses**	**2009 surplus**	2008 surplus
	$	**$**	**$**	$
Transfer payments to HSPs	**2,385,618,620**	**2,385,618,620**	**-**	-
LHIN operations	**5,402,654**	**5,402,654**	**-**	-
E-Health	**425,000**	**425,000**	**-**	-
Patient-Centric Transformation Init.	**223,200**	**223,200**	**-**	-
ER/ALC Performance Lead	**33,300**	**33,300**	**-**	-
Health Force Ontario	**50,000**	**50,000**	**-**	-
Emergency Dept. LHIN Lead	**75,000**	**75,000**	**-**	4,531
Aboriginal Planning	**49,000**	**49,000**	**-**	-
	2,391,876,774	**2,391,876,774**	**-**	4,531

3. Funding repayable to the MOHLTC (continued)

b) The amount due to the MOHLTC at March 31, 2009 is made up as follows:

	2009	2008
	$	$
Due to MOHLTC, beginning of year	**4,531**	-
Funding repayable related to current year activities to the MOHLTC (Note 3a)	**-**	4,531
Amount recovered by the MOHLTC during the year	**(4,531)**	-
Due to MOHLTC, end of year	**-**	4,531

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end, are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared services agreement the LSSO has with all the LHINs.

5. Deferred capital contributions

	2009	2008
	$	$
Balance, beginning of year	**460,145**	618,425
Capital contributions received during the year	**757,016**	66,627
Amortization for the year	**(515,270)**	(224,907)
Balance, end of year	**701,891**	460,145

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years and thereafter are as follows:

	$
2010	162,090
2011	161,776
2012	160,835
2013	156,947
2014	163,313
Thereafter	591,288

The LHIN also has funding commitments to HSPs associated with accountability agreements. The actual amounts which will ultimately be paid are contingent upon LHIN funding received from MOHLTC.

7. Capital assets

	Cost	Accumulated amortization	2009 Net book value	2008 Net book value
	$	$	$	$
Office equipment, furniture and fixtures	**455,333**	**243,040**	**212,293**	153,109
Computer equipment	**125,747**	**89,710**	**36,037**	37,006
Leasehold improvements	**566,951**	**113,390**	**453,561**	270,030
	1,148,031	**446,140**	**701,891**	460,145

As a result of terminating the lease at our former location, effective March 2009, capital assets with a net book value of $135,917 were disposed of during the year.

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget at April 1, 2008. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $2,385,618,620 is derived as follows:

	$
Initial budget	**2,342,686,000**
Adjustment due to announcements made during the year	**42,932,620**
Final budget	**2,385,618,620**

The final operating budget of $6,499,900 is derived as follows:

	$
Initial budget	**4,911,526**
Additional funding received during the year for:	
Leasehold Improvements	**450,000**
New Office Lease	**152,874**
Lease Buy Out for Former Office	**130,000**
E-Health	**425,000**
Patient-Centric Transformation Initiative	**223,200**
ER/ALC Performance Lead	**33,300**
Health Force Ontario	**50,000**
Emergency Department LHIN LEAD	**75,000**
Aboriginal Planning	**37,500**
Aboriginal Planning (Funding from other LHINs)	**11,500**
	6,499,900

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,385,618,620 (2008 - $2,281,812,052) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2009 as follows:

	2009	2008
	$	$
Operation of hospitals	**1,649,379,136**	1,599,087,005
Grants to compensate for municipal taxation - public hospitals	**462,075**	462,075
Long term care homes	**386,280,945**	356,860,092
Community care access centres	**216,335,473**	203,404,489
Community support services	**36,210,913**	29,456,185
Acquired brain injury	**5,726,436**	5,784,897
Assisted living services in supportive housing	**23,025,180**	22,102,042
Community health centres	**11,083,096**	9,060,688
Community mental health addictions program	**57,115,366**	55,594,579
	2,385,618,620	2,281,812,052

The LHIN receives money from the MOHLTC which it in turn allocates to the HSPs. As at March 31, 2009, an amount of $4,559,149 was payable to the HSPs. This amount has been reflected as revenue and expenses with the LHIN's financial activities and is included above.

10. a) E-Health

During fiscal 2009, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $425,000 (2008 - $275,000). These funds were used toward initiatives in support of the 2008 update of the e-health strategic plan.

b) Patient-Centric Transformation Initiative

During fiscal 2008, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $223,200 (2008 - nil). As directed by the MOHLTC, these funds were used to analyze data from across the patient journey, tracking data on the location, type and sequence of services received.

c) ER/ALC Performance Lead

During fiscal 2009, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $33,300 (2008 – nil). These funds were used to support the activities of the ER/ALC Coordinator.

10. (continued)

d) Health Force Ontario

During fiscal 2009, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $50,000 (2008 – nil). These funds were used for the development of a nursing human resource planning strategy.

e) Emergency Department LHIN LEAD

During fiscal 2009, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $75,000 (2008 – $43,800). These funds were used toward initiatives in support of Emergency Department LHIN LEAD activities.

f) Aboriginal Planning

During fiscal 2009, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $49,000 (2008 - $52,500). These funds were used to support Aboriginal Planning activities.

	$
Travel	**2,544**
Consulting services	**11,658**
Meeting expenses	**16,287**
Supplies, other	**18,511**
	49,000

11. General and administrative expenses

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2009	2008
	$	$
Salaries and benefits	**2,900,069**	2,443,819
Director's per diems	**143,725**	126,200
Travel	**99,064**	73,795
Consulting services	**477,484**	325,433
Banking services	**-**	102
Community forums & communication	**127,485**	118,764
Supplies, equipment, maintenance, other	**297,861**	340,805
Accommodation	**541,696**	232,875
Amortization	**515,270**	224,907
Shared services	**300,000**	300,000
General and administrative expenses	**5,402,654**	4,186,700
E-Health funding	**425,000**	275,000
Patient-Centric Transformation Initiative	**223,200**	-
ER/ALC Performance Lead	**33,300**	-
Health Force Ontario	**50,000**	-
Wait List Management Activities funding	**-**	70,000
Aging at Home funding	**-**	295,000
Emergency Department LHIN LEAD funding	**75,000**	39,269
Aboriginal Planning	**49,000**	52,500
	6,258,154	4,918,469

Reconciliation to MOHLTC approved budget:	
General and administrative and initiatives expenses	**6,258,154**
Less: amortization	**(515,270)**
Add: purchase of tangible capital assets	**757,016**
	6,499,900

Included in total travel expenses of $99,064 is $22,900 of travel expenses incurred by the Board of Directors.

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of 27 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2009 was $186,699 (2008 - $169,704) for current service costs and is included as an expense in the Statement of Financial Activities.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

14. Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

15. Comparative figures

Certain prior year comparative amounts have been reclassified to conform with the presentation adopted for the current year.

Board Members

Juanita G. Gledhill
Chair

Jack Brewer
Vice-Chair

Douglas Archibald
Board Member

Carolyn King
Board Member

Robert (Bob) Lawler
Board Member

William (Bill) McLean
Board Member

William (Bill) Millar
Board Member

Janice Mills
Board Member

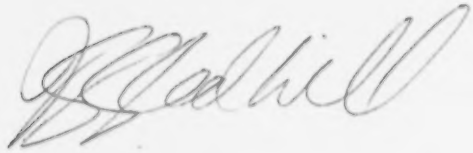
Senior Staff Members

Pat Mandy
Chief Executive Officer

Alan Iskiw
Senior Director,
Performance, Contract and Allocation

Marion Emo
Senior Director,
Planning, Integration and Community Engagement

On behalf of the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to submit this Annual Report for the period ended March 31, 2009.



Juanita G. Gledhill
Chair, Board of Directors

Jack Brewer
Vice-Chair, Board of Directors

Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

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